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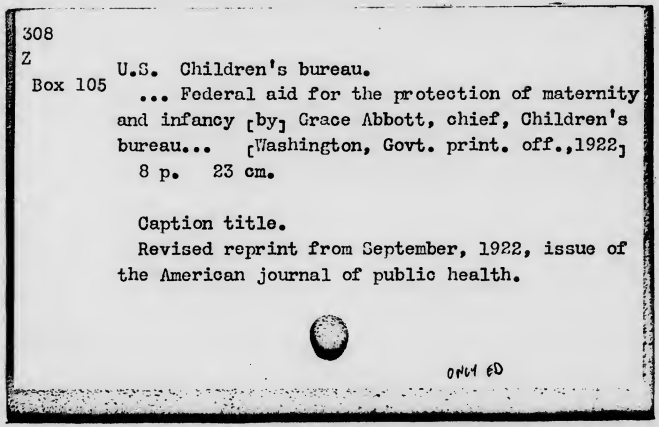
U.S. Children's Bureau

Federal aid for the protection of maternity...

[Washington]

[1922]



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U. S. DEPARTMENT OF LABOR

CHILDREN'S BUREAU

WASHINGTON

FEDERAL AID FOR THE PROTECTION OF MATERNITY AND INFANCY.[1]

GRACE ABBOTT, *Chief, Children's Bureau, Washington, D. C.*

THE reasons which led the Children's Bureau to advocate Federal aid for the promotion of better maternal and infant care by the States are perhaps known to the readers of the Journal. The historical setting is so important that at the risk of repetition, it is summarized here.

The Children's Bureau was created by act of Congress in 1912. Heading a long list of subjects which it is directed by its organic act to investigate is that of infant mortality. Because it was considered of fundamental importance, this subject was the first one to be investigated by the Children's Bureau. The initial study made in an industrial town in 1913 was, at the special direction of Congress, repeated in nine other industrial towns and cities, including Baltimore, Md., and Gary, Ind. Studies of the care available to mothers and infants in typical rural communities of 12 States of the South, Middle West, and West were also made.

The coincidence of a high infant mortality rate with low earnings, poor housing, the employment of the mother outside the home and large families was indicated in all these studies. They also showed that there is great variation in the infant mortality rates, not only in different parts of the United States, but in different parts of the same State and the same city or town. These differences were found to be caused by different population elements, widely varying social and economic conditions, difference in appreciation of good prenatal and infant care, and the facilities available for such care.

Evidence of the methods used in successful efforts to reduce infant mortality was also assembled. The instruction of mothers through

[1] Revised reprint from September, 1922, issue of the American Journal of Public Health.

infant-welfare centers, public-health nurses, and popular bulletins as to the proper care of children, the value of breast feeding, the importance of consulting a doctor upon the first evidence of disease, everywhere brought substantial decreases in deaths, especially from causes classified in the gastrointestinal and respiratory groups. But little progress was made or has since been made in reducing the deaths in early infancy, including deaths caused by premature birth, congenital debility, and injuries at birth. Thus, in the year 1915 the number of infant deaths during the first month of life in the registration area of the United States was more than five times that of the tenth, eleventh and twelfth months, and in 1920 it was still five times as great. Similarly in the year 1915 the number of infant deaths during the first week of life was eight times that in the fourth week, and in 1920 it was nine times as great. Consideration of the causes of infant mortality inevitably leads, therefore, to the question of the care mothers are receiving before, during, and after childbirth.

An analysis of the available statistical information with reference to deaths among mothers was published by the bureau in 1917 and was the subject of much discussion. In a few places the possibility of reducing this death rate about one-half through prenatal supervision in connection with prenatal clinics or maternity centers had been demonstrated.

With the evidence that, as Dr. William Travis Howard, jr., of Johns Hopkins Medical School, has pointed out, "the prevention and control of illness and death of mother and child are among the most neglected and potentially the most fruitful domains of public-health administration," some means for extending on a national scale the successful local work for better care for mothers and infants was obviously necessary.

In her annual report for 1917, Miss Julia Lathrop, in reporting on the bureau's investigation of infant and maternal mortality, called attention to the method of cooperation between national and local government adopted by Great Britain in the so-called grants-in-aid for maternity and infant welfare work and suggested that the United States should use the well-established principle of Federal aid as a basis of national and State cooperation in reducing ~~aid for maternity and infant welfare work and suggested that the~~ unnecessarily high death rate among mothers and babies in this country. The best-known previously enacted laws of this general type were: The Morrill Act of 1862, providing for land-grant colleges; the Hatch Act of 1887, establishing agricultural experiment stations; the Smith-Lever Act of 1914, creating the agricultural extension service; the good-roads act of 1916 (extended in 1919, 1921, and 1922); and the vocational education act of 1917.[2] For an almost innumerable number of objects Congress had granted to the States temporary subsidies from time to time. In view, then, of the overwhelming evidence of the need of promoting on a national scale the health of mothers and babies and the successful demonstration by a number of both public and private agencies in different parts of the country of what could be done through maternity and well-baby centers, it was but logical to resort to the method of State and Federal cooperation which had been so frequently used for less important ends.

The Sheppard-Towner Act for the promotion of the welfare and hygiene of maternity and infancy, which became a law November 23, 1921, is in all essentials the same as the plan for the "public protection of maternity and infancy" submitted by Miss Lathrop in her annual report for 1917. Briefly summarized, its most important provisions are as follows:

(1) *Appropriation.*—It authorizes an appropriation of $1,240,000 for a five-year period, of which not to exceed $50,000 may be expended by the children's bureau for administrative purposes and for the investigation of maternal and infant mortality, the balance to be divided among the States accepting the act as follows: $5,000 unmatched to each State, and an additional $5,000 to each State if matched, the balance to be allotted among the several States on the basis of population, and granted if matched.

(2) *Administration.*—National administration of the act is lodged with the children's bureau of the Department of Labor; local administration in the States is in the child hygiene or child welfare division of the State agency of health, or where such a division does not exist, the agency designated by the State.

(3) *Plan of work.*—The act intends that the plan of work shall originate in the State and be carried out by the State. A Federal Board of Maternity and Infant Hygiene, composed of the Chief of the Children's Bureau, the Surgeon General of the United States Public Health Service, and the United States Commissioner of Education may approve or disapprove State plans, but the act provides that the plans must be approved by the Federal board if "reasonably appropriate and adequate to carry out its purposes."

As originally introduced the act provided that the funds were to be expended by the States for "provision of instruction in the hygiene of maternity and infancy through public-health nursing, consultation centers, and other suitable methods; and the provision of medical and nursing care for mothers and infants at home or at a hospital when necessary, especially in remote areas." These specific provisions do not appear in the act as passed, and the only prohibi-

[2] The industrial rehabilitation act has since been passed (1920).

tions are that no part of the funds is to be expended for the purchase, erection, or repair of any building or equipment, or for the purchase or rental of any buildings or lands, or for any maternity or infancy stipend, gratuity, or pension. While the act was passed November 23, 1921, the money was not made available until the following April. The second deficiency act, passed March 20, 1922, carried an appropriation of $490,000 for the balance of the fiscal year ending June 30, 1922, and the appropriation act for the Departments of Commerce and Labor for the fiscal year ending June 30, 1923, provides $1,240,000 for the purposes of the maternity and infant hygiene act. Some preliminary decisions and approval of forms by the Comptroller of the Treasury were necessary, so that the first money was not paid to the States until May of 1922.

Up to date (November 1, 1922) 42 States have accepted the terms of the act—all except Maine, Massachusetts, Rhode Island, New York, Louisiana, and Washington. Twelve of these acceptances (New Hampshire, Delaware, New Jersey, Maryland, Virginia, South Carolina, Georgia, Kentucky, Mississippi, Minnesota, Oregon, and New Mexico) are by State legislatures and the remaining 30 by governors pending the next regular session of the legislatures.

The amounts available to the States for the fiscal years ending June 30, 1922, and June 30, 1923, are as follows:

Maximum amounts available to the States for the fiscal year ending June 30, 1922.

State.	Granted if matched, apportioned on basis of population.	Total, including $240,000 granted outright ($5,000 to each State).	State.	Granted if matched, apportioned on basis of population.	Total, including $240,000 granted outright ($5,000 to each State).
Total	$237,500.00	$477,500.00	Montana	$1,238.31	$6,238.31
			Nebraska	2,924.66	7,924.66
Alabama	5,297.56	10,297.56	Nevada	174.63	5,174.63
Arizona	753.88	5,753.88	New Hampshire	999.61	5,999.61
Arkansas	3,953.03	8,953.03	New Jersey	7,119.83	12,119.83
California	7,731.12	12,731.12	New Mexico	812.96	5,812.96
Colorado	2,119.83	7,119.83	New York	23,429.70	28,429.70
Connecticut	3,114.75	8,114.75	North Carolina	5,773.47	10,773.47
Delaware	503.10	5,503.10	North Dakota	1,459.36	6,459.36
Florida	2,184.90	7,184.90	Ohio	12,993.41	17,993.41
Georgia	6,533.10	11,533.10	Oklahoma	4,575.88	9,575.88
Idaho	974.30	5,974.30	Oregon	1,767.35	6,767.35
Illinois	14,631.03	19,631.03	Pennsylvania	19,672.69	24,672.69
Indiana	6,611.07	11,611.07	Rhode Island	1,363.54	6,363.54
Iowa	5,423.56	10,423.56	South Carolina	3,798.54	8,798.54
Kansas	3,991.51	8,991.51	South Dakota	1,436.07	6,436.07
Kentucky	5,452.00	10,452.00	Tennessee	5,274.35	10,274.35
Louisiana	4,057.50	9,057.50	Texas	10,520.41	15,520.41
Maine	1,732.66	6,732.66	Utah	1,013.85	6,013.85
Maryland	3,270.49	8,270.49	Vermont	795.09	5,795.09
Massachusetts	8,691.06	13,691.06	Virginia	5,209.61	10,209.61
Michigan	8,276.07	13,276.07	Washington	3,060.58	8,060.58
Minnesota	5,385.44	10,385.44	West Virginia	3,302.16	8,302.16
Mississippi	4,039.70	9,039.70	Wisconsin	5,938.04	10,938.04
Missouri	7,679.67	12,679.67	Wyoming	438.57	5,438.57

Maximum amounts available to the States for the fiscal year ending June 30, 1923.

State.	Apportioned on basis of population.	Granted if matched. Total (if matched)[1].	Grand total.[2]
Total	$710,000.00	$950,000.00	$1,190,000.00
Alabama	15,836.95	20,836.95	25,836.95
Arizona	2,253.71	7,253.71	12,253.71
Arkansas	11,817.51	16,817.51	21,817.51
California	23,112.01	28,112.01	33,112.01
Colorado	6,337.20	11,337.20	16,337.20
Connecticut	9,311.48	14,311.48	19,311.48
Delaware	1,504.01	6,504.01	11,504.01
Florida	6,531.72	11,531.72	16,531.72
Georgia	19,530.55	24,530.55	29,530.55
Idaho	2,912.66	7,912.66	12,912.66
Illinois	43,739.10	48,739.10	53,739.10
Indiana	19,763.62	24,763.62	29,763.62
Iowa	16,213.60	21,213.60	26,213.60
Kansas	11,932.52	16,932.52	21,932.52
Kentucky	16,298.64	21,298.64	26,298.64
Louisiana	12,129.80	17,129.80	22,129.80
Maine	5,179.77	10,179.77	15,179.77
Maryland	9,777.05	14,777.05	19,777.05
Massachusetts	25,981.70	30,981.70	35,981.70
Michigan	24,741.11	29,741.11	34,741.11
Minnesota	16,099.65	21,099.65	26,099.65
Mississippi	12,076.58	17,076.58	22,076.58
Missouri	22,958.19	27,958.19	32,958.19
Montana	3,701.91	8,701.91	13,701.91
Nebraska	8,743.21	13,743.21	18,743.21
Nevada	522.06	5,522.06	10,522.06
New Hampshire	2,988.31	7,988.31	12,988.31
New Jersey	21,284.55	26,284.55	31,284.55
New Mexico	2,430.33	7,430.33	12,430.33
New York	70,041.78	75,041.78	80,041.78
North Carolina	17,259.66	22,259.66	27,259.66
North Dakota	4,362.74	9,362.74	14,362.74
Ohio	38,843.46	43,843.46	48,843.46
Oklahoma	13,679.48	18,679.48	23,679.48
Oregon	5,283.46	10,283.46	15,283.46
Pennsylvania	58,810.99	63,810.99	68,810.99
Rhode Island	4,076.28	9,076.28	14,076.28
South Carolina	11,355.65	16,355.65	21,355.65
South Dakota	4,293.11	9,293.11	14,293.11
Tennessee	15,767.55	20,767.55	25,767.55
Texas	31,450.52	36,450.52	41,450.52
Utah	3,030.89	8,030.89	13,030.89
Vermont	2,376.90	7,376.90	12,376.90
Virginia	15,574.00	20,574.00	25,574.00
Washington	9,149.55	14,149.55	19,149.55
West Virginia	9,871.74	14,871.74	19,871.74
Wisconsin	17,751.62	22,751.62	27,751.62
Wyoming	1,311.12	6,311.12	11,311.12

[1] Includes $240,000 granted if matched ($5,000 to each State).
[2] Includes $240,000 granted outright ($5,000 to each State) in addition to amounts granted if matched.

Up to date (November 4, 1922) payments have been made to 41 States from 1922 funds, and to 39 States from 1923 funds. Of the 41 States that have received payments from 1922 funds, 21 matched their full allotment, 5 matched part of their allotment, and 15 accepted the $5,000 granted outright without matching. Of the 39 States that have received payments from 1923 funds, 13 matched their full allotment, 15 matched part of their allotments, and 11 accepted the $5,000 granted outright without matching.

The Federal Board of Maternity and Infant Hygiene met on April 18, 1922, elected the Chief of the Children's Bureau chairman of the board, and proceeded to consider the plans submitted by States

accepting the act. The board has laid down no plan of work which a State must follow nor has it made approval of plans contingent on complying with certain conditions, each plan being considered on its merits.

The plans submitted by the States and approved by the board vary greatly. The best planning for a State requires a correlation of the money available with the number and causes of deaths among mothers and babies in the different parts of the State and the available local facilities. Unfortunately, 18 of the States accepting the act have not as yet sufficiently complete registration of births to be counted in the birth-registration area and 11 are not in the death-registration area. Obviously their plans can not have the fact basis which is so desirable. Practically all these States are making the Sheppard-Towner Act the basis for a new effort to secure a new law for the enforcement of the one already enacted.

In some States an infant-welfare program has been started and the Federal money can be used in the development of plans already tested by local experience, but in a much smaller number is the program for maternity care anything like so well developed; hence preliminary educational work in this field is generally necessary. Examples of plans on which the States are starting their work will make the value of the law clear.

One State, whose budget for 15 months with the Federal funds amounts to $62,269.02, has selected two counties as training and demonstration centers in maternity and infant care, where special attention will be given to the development and standardization of plans of work. These training bases offer the following variety of problems: (1) Strictly city problems; (2) small town problems; (3) problems connected with mining camps and industrial communities; (4) rural problems associated with agricultural pursuits and involving isolation, poverty, and ignorance to a marked degree. In this State inauguration of a maternity and infancy program in connection with the already established county health units will be possible in at least five additional counties. Efforts will be made to secure the adoption of a maternity and infancy program in the remaining 15 counties having organized county health units. In counties having no full-time health service a general study of the racial elements of the population and the possibilities of local cooperation will be made, and campaigns to secure registration of all births, use of "drops" in the eyes of new-born babies, and reporting of cases of ophthalmia neonatorum will be made.

A program for another State, involving an expenditure of approximately $176,967.36 for 15 months, provides for 2 field physicians, 6 supervising nurses, 4 full-time nurses, and 80 nurses who will give half time to the maternity and infancy work. In this State special

attention is to be given to the training and supervising of midwives. The number of prenatal centers in the State is to be greatly increased, as is the number of well-baby clinics.

Another State, which will have available $61,567.22 for a 15 months' program, has a fairly well-developed county organization for public-health work, and there is general local appreciation of the value of work for mothers and babies. In this State nurses are to be placed in counties already organized, who will devote themselves to maternity and infancy. Supervision of midwives, the number of whom is estimated at some 6,000, inspection of maternity hospitals, as well as conducting prenatal and child-hygiene centers, are included in the plans.

In another State which will have only the unmatched Federal funds, $10,000, general educational work will be done from the central office, and two demonstrations, one in a town and one in a rural district, of the work of an infant welfare and prenatal center will be made.

One of the smaller Eastern States, with a well-developed child-hygiene program and a budget of $76,808.76, proposes to reduce the maternal mortality by (1) instruction of mothers through prenatal clinics, (2) investigation of all puerperal deaths attended by midwives, (3) supervision of midwives, and (4) cooperation with hospitals. The infant mortality rate will be reached through prenatal care offered the mothers and the instruction of mothers in infant care. This State will have a staff of 44 nurses, enough to make possible a visit to all new-born babies, and the follow-up work for the "Baby-Keep-Well Stations" which are being developed, and the licensing and supervision of boarding homes. Two social workers will give special attention to the problem of preventing unnecessary separation of mothers and babies.

In contrast, a large western State which has only the unmatched Federal funds, plans general educational work as to the needs and possibilities of an infant and maternal hygiene program, will make its first survey of the State's problems—geographic distribution of maternal and infant deaths, causes, available local facilities, etc.—and will employ the school nurses of the State during the summer months for infant-welfare work.

A State in the Middle West plans regular monthly conferences at a series of maternity centers that will be opened throughout the State; a Child Welfare Special will visit six communities, holding children's health conferences at stated intervals; institutes will be held to instruct women who will act as "mother's helpers" in the care of the home and other children during and after the mother's confinement; and Little Mothers' Classes will be organized in the schools.

Any public-health work is, shall we say, at least three-fourths educational. The widespread discussion of the Sheppard-Towner Act has already done much to acquaint women and legislators with the importance of scientific care of mothers and their babies. Thus New York, Massachusetts, and Maine, although not accepting Federal assistance, have made their first appropriations for the promotion of the hygiene of maternity, as a result of discussion of the Sheppard-Towner Act. Whether considered separately or in relation to other States or Nations, every State must face the fact that there is a general demand that whatever the source or character of the opposition, the large and preventable loss of life among mothers and babies must be reduced. But the value of the work is not limited to the saving of life.

All the examinations of cross-sections of the population made in connection with preschool clinics, school medical inspection, medical certification of children for work permits, examinations of all the men in connection with the draft, show substantially the same high percentage of physical subnormality. Care of the mother and the child from birth is the foundation on which a national program for real physical fitness must be built. Subsequent work is remedial, not preventive.

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